DAILY INFANT REPORT

For: _____ **Date:** _____

INFORMATION FROM PARENTS

Infant slept: ☐Good ☐OK ☐ Not well

Infant seems: ☐Happy ☐Fussy ☐Other

Comment: _____

Infant ate before coming:

☐No ☐Yes Time: _____

Amount: _____

Has infant had medication before coming? ☐No ☐Yes**

** What time: _____

** What medicine & amount: _____

_____

** Reason for medicine _____

_____

Special requests for infant today:

_____

_____

_____

_____

_____

_____

_____

_____

When will infant be picked up and by whom?

_____

_____

INFORMATION FROM CENTER

Diapering/Toileting

Time	Wet	BM	Description
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____

Naptime/Sleeping

Went to sleep: Woke up:

Activities

Music _____

Reading _____

Motor activities _____

_____

Outside _____

Other _____

Eating and Snacking

Time Food/Amounts

Medication

Time	Name	Amount	Staff initial
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Disposition

(Circle one)

AM – Baby seemed Happy / Fine / A little fussy / Not well

(Circle one)

PM – Baby seemed Happy / Fine / A little fussy / Not well

Center additional comments: _____

_____

Parent Signature: _____ Caregiver Signature: _____